Surveyor's Here !!!!!!!!!!!

Going through a Medicare and State Survey

www.cms.hhs.gov/center/hospice.asp

Clinical Records

The minimum number of clinical records to be reviewed during the hospice survey will be the sum of the number of clinical records without home visits and the number of clinical records with home visits. See chart below.

Unduplicated Admissions	Minimum # of Record Reviews without Home Visit	Minimum # of Record Reviews with Home Visit	Total Record Reviews
<150	8	3	11
150-750	10	3	13
751-1250	12	4	16
1251 or more	15	5	20

Handout 2

Initial Assessment (L522)

1) Done by RN within 48 hours after election of hospice care unless physician/patient or caregiver requests an assessment earlier than 48 hours.
2) Completed in the location hospice services will be delivered.
3) Includes important information that identifies the immediate needs of the patient/family including psychosocial, spiritual, physical and emotional needs.
4) Is not a "meet and greet" visit.
5) Must begin the plan of care.
6) The beginning of the comprehensive assessment that determines the involvement of other disciplines, including core and non core services.

Handout 3

Assessment Timeframes

(example)

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2 Effective Date of election	3 Day 1	4 Day 2 Initial assessment due	5 Day 3	6 Day 4	7 Day 5 CA completed

Per CMS Webinar

Comprehensive Assessment (L523)

1) Must be completed in 5 calendar days after the election.
2) Must include interdisciplinary group and the attending physician (if any).
3) The medical director must assume the role of the attending physician if the attending physician is unavailable.
4) L534 – must include data elements that allow for measurement of outcomes.
5) Hospices must measure and document data in the same way for all patients.
6) L535 – data elements must be used in individual patient care planning and coordination of services.
7) Must be used in the agency for quality assessment and performance improvement program.

Content of Comprehensive Assessment Must Include (L524)

1) Physical Needs
2) Psychosocial Needs
3) Emotional Needs
4) Spiritual Needs

Also the following factors must be included (L525-L533)

- L525-Nature and Condition Causing Admission
- L526-Complications and Risk Factors
- L527-Functional Status
- L528-Imminence of Death
- L529-Severity of Symptoms
- L530-Drug Profile that includes prescription & over the counter drugs, herbal remedies and other alternative therapies that affect drug therapy.
  a) Effectiveness of drug therapy
  b) Side effects
  c) Actual/potential drug interactions
  d) Duplicate Drug Therapy
  e) Drug Therapy with Laboratory Monitoring

- L531 – Bereavement
- L532 – Need for Referrals.

  Remember the initial/comprehensive assessment must include assessment of need for volunteers, homemaker and hospice aide services.
- L533 – Update of Comprehensive Assessment.
  a) Must be accomplished by the hospice interdisciplinary group in collaboration with attending physician, if any.
  b) No less frequently than every 15 days.

*Missouri Regulations states the group will meet no less often than every two weeks.

Content of Plan of Care

- L545-Patient/Family Goals.
- L546-Interventions to Manage Pain and Symptoms.
- L547-Scope and Frequency of Services Needed.
- L548-Measurable Outcomes.
- L549-Drugs and Treatments necessary to meet the needs of the patient.
- L550-Medical Supplies and Appliances.

- L551-Documentation of Patient's/Caregivers Involvement, Understanding and Agreement with the Plan of Care.
- L531-Initial Bereavement Assessment.
- L538-Must specify the care and services necessary to meet patient and family needs identified in all assessments.
- ML157-Physican's Orders

There must be documentation of a collaborative effort in establishing the Plan of Care involving all members of the IDG and the attending physician (if any).

Qualifications for Social Worker per Medicare Regulations

- Master of Social Work from a school of social work and one year experience in a healthcare setting.

or

- Baccalaureate degree from a school of social work and one year experience in a healthcare setting and supervised by MSW.

or

- Baccalaureate degree in psychology, sociology or other related field to social work and one year social work experience in a healthcare setting and supervised by MSW.

or

- Baccalaureate degree from a school of social work and is employed by hospice prior to 12/02/08, therefore, the BSW is not required to be supervised by a Master of Social Work (MSW).

* In the Missouri Regulations, the definition of social worker is "a person who has at least a bachelor's degree in social work from a school of social work accredited by the Council on Social Work Education", therefore, the social worker in Missouri must have graduated with a degree in social work.

QAPI Regulations

Condition of Participation	42 CFR 418.58
418.58(A)	Program Scope
418.58(B)	Program Data
418.58(C)	Program Activities
418.58(D)	Performance Improvement Projects
418.58(E)	Executive Responsibilities

Missouri Performance Improvement Regulation

ML266	(N) Performance Improvement. 1. The hospice shall follow a written plan for assessing and improving program operations which includes: A. Goals and objectives; B. The identity of the person responsible for the program; and C. A method for resolving identified problems.
ML267	2. The plan and performance improvement activities shall be reviewed at least annually by a designated group and the governing body and revised as appropriate.
ML268	3. When problems are identified in the provision of hospice services, the hospice shall document any evidence of corrective actions taken, including ongoing monitoring, revisions of policies and procedures, educational intervention, and changes in the provision of services.
ML269	4. The effectiveness of actions taken to improve services or correct identified problems shall be evaluated.
ML270	5. A designated group shall review and document the performance improvement activities and monitor corrective actions.

Clinical Record Content

L670-L678 ML243-ML250
Clinical Record content must include:

Initial Plan of Care, Updated Plan of Care	Initial Assessment, Comprehensive Assessment and Updated Comprehensive Assessment
Clinical Notes	Signed Copies of Patient's Rights
Signed Copies of Election Statement and Consult	Responses to Medications, Symptom Management, Treatments and Services
Outcome Measure Data Elements	Physician Certification
Recertification if applicable	Advance Directives
Physician Orders	Identification Data
Pertinent Medical History	Determination of Financial Responsibility
Documentation of Communication with Coordinating Providers	

STANDARD CONTRACT TOOL – ALL PROVIDERS (L655)

Hospice Provider Number Date **CONTRACT PROVIDER NAME**	Identification of Services to be Provided ML150 & L655	Provider & Personnel Appropriately Licensed /Certified	Hospice Authorizes Care/Maintains Professional Management	POC Transfers/Updates and Inpatient Services Identified ML152 & L711	Delineation of Roles between Hospice and Contracted Services	Requirements for Documentations of Services in Accordance with Agreement	**How Contracted Services are:**	Coordinated ML152	Supervised L655	Evaluated L655	Hospices Responsible for Patient Care and Complying with Hospice Regs	Hospice Retains Payment Responsibilities L655	Hospice Education to Nursing Facility Staff ML256

ADDITIONAL REQUIREMENTS - INPATIENT ACUTE & RESPITE CONTRACT TOOL

Hospice Provider Number Date **CONTRACT PROVIDER NAME**	Respite Only 24 Hour Nursing to meet Patient Needs	Written Agreement with Qualified Facility L711	Specified Inpatient Services Provided (Pain/Symptom Mgmt) Respite	Policies/Protocols Consistent with Hospice L711 & L712	Facility Agrees to Abide by Hospice Protocol L711 & L712	Medical Record Includes all Inpatient Services and Events L713	DC Summary Provided and Copy of Med. Record (if requested) L713	Person Responsible for Implementation of Agreement L714	Hospice Training Provided to Inpatient Staff L715	24-hr. RN Services/RN Every Shift Inpatient Acute Only L723	Areas for Comfort & Privacy for Patient/Family L729	Space for Private Patient/Family Visiting L729L	Accommodations for Family to Remain at Night L729	Accommodations for Family Privacy After Patient's Death L729	Homelike Décor L729	Visitors Permitted at Any Hour Including Children L729

Handout 10-A

SURVEYOR'S HERE !!!!

Going through a Medicare and state survey----------

Hopefully you have the new Medicare regulations with you and a copy of the handouts that should have been attached with the information regarding this webinar. Here are the web sites if you do not have them

1. **www.cms.hhs.gov/center/hospice.asp (Handout 1)**

2. You may access the Hospice Medicare Interpretive Guidelines at our website at www.dhss.mo.gov/HomeCare and they can be found in the January 2009 Bureau Talk-Attachment D.

3. The state regulations can be found in the October 2008 Bureau Talk-Attachment #5

4. The hospice question and answers section that we will occasionally refer to during this presentation can be found on the January 2009 Bureau Talk-Attachment C and April 2009 Bureau Talk-Attachment B.

Our main objective is for you to see through the eyes of a surveyor with the new Medicare regulations.

The new Medicare regulations came into effect on 12-02-08.

Medicare has increased the number of regulations from 47 to 92 standards.

The Missouri state law requires hospice surveys to be done annually.

The Medicare State Operations Manual has increased the number of home visits and clinical records to be done on survey. **Handout 2** addresses these changes.

The numbers will be based on your unduplicated admissions. This information which is from the statistical report you send to our office every year by January 31. The surveyor will look at your statistical report to determine the number of clinical records and home visits that will be done on survey.

When the surveyor arrives at your agency an entrance interview will be completed.

You will be asked to identify general information about your agency and given forms to complete. You will receive a list of items needed for survey.

Let's go over a few issues:

The certification must include: (L667)

- A 6 month terminal prognosis
- Verbal certification by the attending physician and medical director in 2 calendar days (subpart B 418.22 (a) (3))

-and be signed prior to billing. (418.22 (a) (2))

The recertification (L668) is signed by the medical director or a physician designee.

The election statement must include: (subpart B 418.24 (a) & (b))

-signature of the patient or representative
-date of the election
-Acknowledgement that certain Medicare services are waived.

The consent (ML101) is a state regulation that should include the specific type of care and services that may be provided. Your election statement and consent could be one form if all regulations are met.

PATIENT'S RIGHTS

Patient's rights are new Medicare regulations at L 500-519. Patient's rights have already been regulated in the state regulations.

The information the hospice agency provides to each patient must include both set of regulations. The new Medicare regulations must be addressed in policy.

The Medicare regulations require a signature confirming the patient or representative has received a copy of the patient's rights (L504).

This does not necessarily mean the patient or caregiver has to sign the actual patient rights document but it can be signed if that is what is preferred.

It also could be a checklist, signed by the patient/representative that states the patient/ representative has received a copy of the rights.

**Remember, there must be documentation a copy was given to the patient.

The new Medicare regulations also address alleged violations.

The Patient Rights must include:

--all alleged violations are reported immediately (not to exceed 24 hours after discovery) by hospice employees and contact staff to the hospice administrator (**L508**)

--immediately investigate to prevent further violations (**L509**)

--appropriate corrective actions for verified violations (L**510**)

--If a violation was verified a report must be made to State and local authorities with jurisdiction within 5 working days of becoming aware of the violation (**L511**).

Your agency must have a complaint file that documents the complaint, your follow up and resolution. The federal regulation at L505 also states the staff must be aware of the compliant process for your agency.

The surveyor will ask for your complaint file and new policy.

FINANCIAL INFORMATION (L518)

The patient has a right to know his/her financial responsibility.

The surveyor will expect to see documentation that the patient has been informed of the amount that will be owed

On home visits the surveyor asks the question if the Patient/representative is aware of his/her financial responsibility to the hospice.

Your agency should have a form to document this information and it should be completed.

Insurance patients also have a right to know their financial information and fiscal responsibility if any.

It is the hospice's responsibility to inform them of that information and the surveyor will look for that information in the clinical record.

ADVANCE DIRECTIVES (L503)

This is new for Medicare. The requirements are:

-inform and distribute literature on agency policy for advance directives

-must show if the patient has an advance directive and the type

-if the patient has an advance directive the hospice needs to obtain a copy for the clinical record.

INITIAL ASSESSMENT (L522) (Handout 3)

-- must be done by the RN within 48 hours after the election of hospice care (unless the physician, patient, family request an earlier time)

--must be done in location hospice services will be delivered (the initial assessment cannot be done while the patient is still in the hospital) unless the patient is being admitted under general inpatient level of care.

--must include important information to treat the immediate needs of the patient, including psychosocial, spiritual, physical and emotional needs.

--is not a "meet and greet" visit
--must begin the plan of care
--is the beginning of the comprehensive assessment.

COMPREHENSIVE ASSESSMENT (L523) (Handout 5)

--must be completed in 5 days after the date of election (Handout 4)

--must include IDG and the attending physician (if any)

--the medical director must assume the role of the attending physician if the attending physician is unavailable

--must include data elements that allow for measurement of outcomes (L534)

--hospices must measure and document data in the same manner for all patients

--data elements must be used in individual patient care planning and coordination of services (L535)

--must be used for quality assessment and performance improvement program.

CONTENT OF THE COMPREHENSIVE ASSESSMENT (Handout 5)

Must include:
(L524)

--physical needs
--psychosocial needs
--emotional needs
--spiritual needs

(L525-533)

--nature and condition causing admission (L525)
--complications and risk factors (L526)

--functional status (L527)
--imminence of death (L528)
--severity of symptoms (L529)
--drug profile (L530) that includes prescription and over the counter drugs, herbal remedies and other alternative therapies that affect drug therapy. It also should include
*effectiveness of drug therapy
*side effects
*actual/potential drug interactions
*duplicate drug therapy
*drug therapy with laboratory monitoring
--bereavement (L531)
--need for referrals (L532) (remember the initial/comprehensive assessment must include as assessment of the need for volunteers, homemaker and hospice aide services.

Update of the comprehensive assessment (L533) must include:
-- The changes in the care and services of the patient

--must be done by the IDG in collaboration with the attending physician (if any)

--No less frequently than every 15 days.

*Let us clarify… the initial/comprehensive assessment are new Medicare regulations. Even though the words <u>initial</u> and <u>comprehensive</u> assessment are not used in the MO regulations the MO regulations do address at ML166 that the group will meet no less often that every 2 weeks.

It also states the group is responsible for the provision and coordination of care of all patients. Therefore the MO regulations will take precedence.

*Just to clarify… IF on the initial assessment by the RN psychosocial and/or spiritual services are determined NOT to be needed at this time (by Medicare standards) the state regulations still require a psychosocial and spiritual assessment to be completed within 7 days of admission on each patient.

This assessment may not be done over the phone and if the patient/family refuse a visit by the SW or Chaplain then an assessment by a member of the IDG must be completed. Example: The RN at the initial assessment.

**Remember the regulation that is more stringent will take precedence and will be enforced.

PLAN OF CARE

---is established by all the IDG in collaboration with the attending physician (if any), patient or representative, and the primary caregiver. (L543)

---must be individualized (L545)

---must reflect the patient and family goals and interventions based on the problems identified in the initial, comprehensive and updated assessments (L545)

---hospice must train and educate the patient/caregiver in their responsibilities for care and services identified in the plan of care (L544)

---state regulation states at ML 155 the plan of care shall be established within 7 days of admission.

**Remember we are talking about the plan of care here—NOT the initial and comprehensive assessment.

Also remember the Federal regulation at **L552 requires a review and revision of the plan of care by the IDG and attending physician at least every 15 days **but** the MO regulation (**ML158**) requires the review and revision every 2 weeks. Therefore the MO regulation will take precedence.

CONTENT OF THE PLAN OF CARE (see handout 6)

---patient/family goals (**L545**)

---interventions to manage pain and symptoms (**L546**)

---scope and frequency of services needed (**L547**)

---measurable outcomes (**L548**)

---Includes progress toward meeting outcomes

---drugs and treatments necessary to meet the need of the patient (**L549**)

---medical supplies and appliances (**L550**)

---documentation of patient/caregiver involvement, understanding and agreement with the plan of care (**L551**)

---initial bereavement assessment (**L531**)

---must specify the care and services necessary to meet patient and family need identified in all assessments (**L538**)

--(MO regulation at **ML157**)—physicians orders

There must be documentation of a collaborative effort in establishing the plan care involving all members of the IDG and the attending physician, if any.

CMS refers to the hospice plan of care as "a detailed roadmap."

PAIN MANAGEMENT AND SYMPTOM CONTROL

Pain management and symptom control are addressed several places in the new Medicare regulations.

Patient rights address effective pain management and symptom control (**L512**)

(L**524**) In the interpretive guidelines the regulation addresses the pain assessment and the surveyor will be looking to see if specific issues are addressed which are:

1. History of pain and treatment
2. Characteristics of pain which include:
   a. Intensity
   b. Description
   c. Pattern
   d. Location and radiation
   e. Frequency, timing and duration
   f. Impact of pain on quality of life
   g. Factors that precipitate or exacerbate
   h. Factors that reduce pain
   i. Any addition symptoms associated with pain
   j. Physical exam
   k. Current medication and condition
   l. Patient/family goals for pain management
   m. Satisfaction with current level of pain control

Nurses should already be doing these assessments and initiating interventions. The difference is …Now it's in Medicare regulation!

Surveyors will look to assure the plan of care addresses interventions to manage pain and symptoms which could include medication changes and any other alternative therapies.

Let's address the Medication List (**L530**)

There should be a documented review of all patient :

1. Prescription drugs
2. Over-the-counter medications
3. Herbal remedies
4. Other alternative treatments that could affect drug therapy.

This includes:

1. Effectiveness of drug therapy
2. Drug side effects
3. Actual or potential drug interactions
4. Duplicate drug therapy
5. Drug therapy currently associated with laboratory monitoring.

We received a QUESTION that said: Are the medication reviews required to be done every 15 days if there are no changes in the medications?

ANSWER: Per 418.54 (c)(6), Interpretive Guidelines, "…The hospice should review each patient's medications and monitor for medication effectiveness, actual or

potential medication-related effects, duplicate drug therapy and untoward interactions **during each update** to the comprehensive assessment, **and as new medications are added or changed,** or patient's conditions changes. "Per 418.54 (d), "…The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days." The agency must have documentation that the medication reviews were done. **NOTE:** Whenever the state regulations are more stringent than the federal COPs, the agency must adhere to the state requirement. In this instance, the state regulations ML158 states, "The plan shall be reviewed and updated by the interdisciplinary group at a minimum of every two weeks. These reviews shall be documented in the patient record." Therefore, medication reviews in Missouri are required to be done every 14 days.

(**ML214**) The Medications listed on the drug profile must have physician orders that include:

1. Name
2. Dose
3. Frequency
4. Route

(**L690**) Only a physician or a Nurse Practitioner (per state law) may order drugs for the patient.

If the order is verbal or electronic transmission it must be given to a licensed nurse, NP, pharmacist or physician.

The person receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with state and federal regulation.

(**L692**) The IDG must determine and document the ability of the patient and/or family to safely self administer drugs and biological to the patient in his/her home.

The state regulation at ML222 states the RN must document this evaluation.

The state regulation at ML222 takes precedence over the Federal regulation.

(L688) There must be an individual with education and training in drug management who is an employee or under contract with the hospice that ensures the drugs and biological meet each patient's needs.

We're going to make reference to several questions regarding this new medication regulation.

QUESTION: Would a nurse who takes and passes the Hospice and Palliative Nurse exam qualify and meet the requirements of the regulation at 42 CFR 418.106 (a) Managing drugs and biological?

ANSWER: Per 418.106 (a), Interpretive Guidelines, "…Individuals with education and training in drug management may include: licensed pharmacists,

physicians who are board certified in palliative medicine; **RNs who are certified in palliative care;**…" a representative from the National Board for Certification of Hospice and Palliative Nurses states, "…the NBCHPN certification in hospice and palliative care is the palliative care certification reference in the interpretive guidelines to the regulation at 42 CFR 418.106 …This is one measure CMS is employing to ensure that the RN has the ability to evaluate a drug profile."

Another question we feel needs addressed:

QUESTION: The new regulations state the hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures. Can the medical director fulfill this role?

ANSWER: Hospices must confer with an individual with education and training in drug management, and use acceptable standards of practice for hospice patients to select the most appropriate drugs to meet a particular patient's need. Conferences may take place in person or through other means of communication (e.g. teleconference, FAX, electronically, etc.). Individuals with education and training in drug management may include: licensed pharmacists; physicians who are board certified in palliative medicine; RNs who are certified in palliative care; and physicians , RNs and nurse practitioners who complete

a specific hospice or palliative care drug management course, and other individuals as allowed by State law. The bureau has determined that, if it is your agency's policy that the medical director and /or attending physician are responsible for the drug management of the patient, that physician would be allowed to fulfill the role mandated by this regulation. (**L688**).

(**ML215**) The variable doses of medication must include maximum doses/frequency and reason.

(**ML219**) Medications use must be reviewed with patient/family

CONTROLLED SUBSTANCES

(**L694**) Hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home.

(**L695 & L696**) The hospice must provide a copy of agency's policy and procedure on management and disposal of controlled drugs to the patient or representative and family and discuss those policies and procedures in a language and manner that is understandable by all parties.

The surveyor will look for documentation in the clinical record that the policy and procedure were provided and discussed. (**L697**)

I want to refer to one of the questions in the Q & A handout. The question is… "If a hospice admits a patient who is already on a controlled substance should the agency treat that as if it is a first order of the medication and provide the policy and teaching per regulation or do we do that only if we are starting a controlled medication on a current patient?

Answer: If the patient is on a controlled substance at the time of admission the agency would need to suffice the regulation with giving copies of your policies and procedures.

*** (**ML217**) State regulation concerning controlled substances has not changed and the surveyor will continue to look for documentation of controlled substance delivery that includes:

a. Date
b. Patient name
c. Medication name
d. Strength
e. Quantity
f. Signature of hospice staff
g. Receiving person

(**ML218**) It is also the hospice's responsibility to document the misuse of a controlled substance and to notify the prescriber.

COORDINATION OF SERVICE

The hospice must develop and maintain a system of communication and integration in accordance with the hospice's own policies and procedures to:

1. Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervision of the care and services provided

2. Ensure that the care and services are provided in accordance with the plan of care

3. Ensure that the care and services provided are based on all assessments of the patient and family needs

4. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all setting, whether the care and services are provided directly or under arrangement and

5. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

The surveyors would expect to see documentation in the clinical record of the sharing of information between all disciplines providing care and with other healthcare providers furnishing services to the patient. **(L554, L555, L556, L557 and L558)**

CORE SERVICES

MEDICAL DIRECTOR

(L669) One team member of the hospice team is the Medical Director.

There is only one Medical Director that assumes the overall responsibility for the medical component of the hospice's program.

IF there is more than one physician on the IDG the Medical Director would supervise those physicians.

The other physician team members would continue to fill the role of the physician on each IDG team.

Therefore there can be only one Medical Director who is clearly defined even though there may be multiple physician members of the team.

REGISTERED NURSE:

Another member of the core team is the RN.

The registered nurse responsibilities have not changed. The RN is still responsible for the on-site supervisory visit every 2 weeks of the aide. The aide does not have to be present during this supervisory visit. However there is additional responsibility for the RN involving aide supervision. If on this visit a concern is identified the Federal regulation at **L630** requires the supervisory nurse to conduct an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while performing care.

The Federal regulation at **L631** states:

1. If the concern is verified during the onsite visit the aide must complete a competency evaluation per state law.

2. This would include the Missouri state competency exam and competency evaluation part II (which is the skills check list). This is NOT a new test. It is the SAME one we have always required.

On survey we frequently find the supervisory RN documenting the aide is following the plan of care. Often a review of the clinical record reveals the aide may not consistently follow the aide plan of care.

The supervisory RN must assure the aide follows the plan of care and that the patient/family is satisfied with the services. If the surveyor makes a home visit and finds a concern with aide services then a deficiency may be written.

The regulations also state at **L632** that an RN must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess **each** aide while he/she is performing care.

Therefore **all aides employed by your hospice must have an annual on-site visit with the aide while providing care**.

The surveyor will look for this documentation.

Additional core services include:

1. Medical Social Services

2. Counseling

Let's discuss Medical Social Services.

The new Federal regulations at **L787** require a Social Worker to have a: (**Handout 7**)

1. A Masters of Social Work degree from a school of social work and one year of SW experience in a health care setting **OR**

2. A baccalaureate degree from a school of social work and one year of SW experience in a health care setting and supervised by a MSW **OR**

3. A baccalaureate degree in psychology, sociology or other field related to social work and at least one year of SW experience in a health care setting and supervised by a MSW **OR**

A social worker that has a baccalaureate degree from a school of social work and is employed by the hospice before 12/02/08 is not required to be supervised by an MSW.

Any hospice that hires a BSW after 12/02/08 will need an MSW to supervise that position and will need to have a policy in place that addresses the supervision.

All of these are new Medicare regulations.

***In the Missouri regulations, the definition of social worker is "a person who has at least a bachelor's degree in social work from a school of social work accredited by the Council on Social Work Education" therefore, the social worker in Missouri must have graduated with a degree in social work."

This takes precedence over the Federal regulation that addressed the degree in psychology, sociology or other related fields to social work.

The surveyor will look at your social workers date of hire and credentials.

COUNSELING SERVICES include:

1. Bereavement (L596)
2. Dietary (L597)
3. Spiritual (L598)

BEREAVEMENT counseling includes more specific criteria for your program. That criteria includes:

1. An organized bereavement program
2. A program available for 1 year (this includes NH patients)
3. A program that reflects the needs of the bereaved
4. A plan of care with frequency of service

Don't forget… the state regulations require a 2 month risk assessment VISIT and a 6 month VISIT. Both visits must be ON-SITE in order to accurately assess the needs of the bereaved.

DIETARY counseling:

(L597) Hospices must assure the dietary needs of the patient are met by a qualified individual.

If an RN is capable of meeting the patient's needs then the dietary counseling can be provided by the RN.

If the needs of the patient exceed the expertise of the nurse then the hospice must have available an appropriately trained and qualified individual such as registered dietician or nutritionist to meet the patient's dietary needs.

At **ML198** the regulation states dietary counseling must be done by a qualified dietary counselor. The definition in the Missouri regulations of a dietary counselor is "an individual that is currently eligible to be licensed as a dietician in Missouri or recognized as a nutritionist.

Therefore the state regulation takes precedence over the Federal regulation for the state of Missouri.

SPIRITUAL counseling:

The only additional requirement is… if a need is identified on the initial assessment by the RN then a comprehensive assessment must be done in 5 days.

However, if no need is identified the **state** regulations require a spiritual assessment within 7 days of admission.

Spiritual counseling provides:

1. An assessment of the patient and family spiritual needs

2. Meets the needs in a manner consistent with patient and family beliefs and desires

3. Make efforts to facilitate visits by pastoral counselors and other individuals who support the patient's spiritual needs.

4. Advise the patient and family of this service.

NON-CORE SERVICES:

These services include

1. Physical Therapy
2. Occupational Therapy
3. Speech Therapy
4. Hospice Aide
5. Homemaker
6. Volunteer

VOLUNTEERS

Every hospice MUST have a volunteer program that meets the needs of the patients and meets both the state and federal regulations.

When a need is determined the service must be provided in a timely fashion and care must be provided in ALL THE COUNTIES OF THE SERVICE AREA.

*We want to be sure and stress that the volunteer does not have to live in the county but a volunteer must be willing to cover that area if a need for a volunteer arises.

We continue to get the proverbial question regarding crafts including lap robes, seasonal baskets, etc.

A question was sent to us regarding this issue.

QUESTION: Can activities and time spent by official hospice volunteers making lap robes, fixing seasonal baskets, etc. be counted toward volunteer hours if we deliver the items to the patient? Could we consider the time spent making them as administrative hours and the time spent taking them to the patient as direct patient care time? These activities are not being used for fund raising.

ANSWER: NO. The response from CMS is as follows:

"We had a question a few months ago that was similar and it involved a hospice wanting to use hours that a volunteer had used to make quilts. CMS did not view "quilting" as a legitimate administrative or direct patient care activity and such volunteer hours should not be used to compile volunteer hours or in computing the cost savings…making lap robes and fixing seasonal baskets falls into the same category as quilting. It is not appropriate for administrative consideration"

Although this is a very nice thing for a volunteer to do and may even help in the retention of volunteers this time CANNOT be counted.

INTERDISCIPLINARY GROUP

The Federal regulation at **L537** states the hospice must designate an interdisciplinary group or groups in consultation with the patient's attending physician and prepare a written plan of care.

The group members must provide care and services offered by the hospice (**L539**).

The entire group must supervise the care and services that meets the physical, psychosocial, emotional and spiritual needs of the patient/family.

The IDG must include (but not limited to) individuals who are qualified and competent to practice in the following roles:

1. Doctor of medicine or osteopathy (who is an employee or under contract with the hospice)
2. A registered nurse
3. A social worker
4. A pastoral or other counselor as we described in the CORE services

(**L540**) An RN who is a member of the IDG must be designated to:

1. provide coordination of care
2. ensure continuous assessment of patient/family needs
3. Implement the plan of care.

If there is more than one IDG, the hospice must identify a specifically designated IDG to establish policies governing the day to day provision of hospice care and services. (**L542**)

REVOCATION

Revocation is ONLY a Medicare issue. The state regulations do not address revocation !

Revocation is a decision made by the patient/family.

The hospice CANNOT revoke the patient.

The surveyor will note the reason the patient chose revocation.

Revocation CANNOT be coerced in any manner.

The revocation statement must include:

1. Date of revocation
2. Signature by the patient or patient representative (**subpart B 418.28**)

The IDG must be informed of the revocation.

***This is a new regulation at **L683**. If the patient revokes the election of hospice care, the hospice must send to the attending physician a copy of:

1. Discharge summary
2. Patient's clinical record (if requested)

(**L684**) The Discharge summary must include:

1. Summary of the patient's stay including treatment, symptoms and pain management

2. Current plan of care

3. Latest physician orders

4. Any other documentation that will assist in post-discharge continuity of care

5. Any other documentation requested by the attending physician or receiving facility.

The surveyor will look for the date the information was sent to the physician.

TRANSFER/CHANGE OF DESIGNATED HOSPICE

Each clinical record shall be a comprehensive compilation of information (**ML240 and L672**)

The clinical record should include the reason for transfer.

A Transfer summary must be sent to the receiving provider with at least the following information:

1. Current Medication List (**ML104**)

2. Advance Directives (if applicable) (**ML104**)

3. Problems that require intervention or follow up (**ML104**)

4. A Discharge summary of the patient's stay to the physician. (**L684**)
   (Refer to above list of items in discharge summary)

5. A copy of the clinical record (if requested) by the receiving provider (**L682**)

If transferring to another hospice a transfer form needs to be present in the clinical record and signed by the patient/patient representative stating the transfer date, the transferring hospice and receiving hospice (Subpart B 418.30 (c) (1) (2).

The surveyor will look for the date the information was sent.

DISCHARGE

The clinical record should include a documented reason for discharge (**ML105; Subpart B 418.26(a)**)

Need to see documentation that the patient/patient representative has been notified of the date and reason for discharge (**ML106**).

We must see team involvement (**L551 and L554**).

Must have a written order from the hospice medical director (**L678**). (also at subpart B 418.26 (b)

We must see documented consultation with the attending physician (**ML108**)

The discharge summary must be sent to the attending physician. (**L683 and L684**)

We've already discussed what the discharge summary will include.

Referral must be made to the appropriate resources (**L551, L556 and ML107**).

CONTINUOUS CARE

Let us address continuous care.

We have had several issues with agencies providing continuous care when that care did not meet the definition of the regulation.

1. Continuous care can only be provided during periods of crisis.

An example being: When the patient requires continuous care to achieve palliation or management of acute medical symptoms.

2. The imminent dying process would not necessarily require continuous care.

3. Documentation should clearly identify the need for continuous care.

4. The plan of care, the comprehensive assessment and updates must support the need for continuous care.

INPATIENT-ACUTE

Acute inpatient for symptom management and pain control has not changed.

The surveyor will look for the following:

1. Each shift has an RN who provides direct patient care **(418.108 and 418.110 (b) (2))**

2. Team involvement **(L554-L558) (ML168)**

3. Patient and family needs are met **(L650) (ML151)**

4. Periodic contact with staff, patient and family **(L650 and L714) (ML151 and ML152)**

5. Hospice made arrangements for the admission **(L711)**

6. The inpatient facility has the patient's current hospice plan of care (**L711**)

7. The hospice plan of care includes the inpatient services to be furnished (**L711**)
8. The plan of care is updated in the facility (**L552 and L553) (ML159**).
9. Hospice must have a contract with the facility

INPATIENT-RESPITE

A facility providing respite services would be expected to follow all the inpatient- acute rules as already stated.

If only respite is provided in a facility the old regulation that a RN has to be on each shift has been dropped. The regulation says that for respite the facility must provide 24 hour nursing services that meets the patient's needs according to the plan of care. Remember this is respite only. Inpatient acute must have an RN on each shift **(418.110 (b) (1))**

In the April 2009 Bureau Talk in the Question and Answer attachment, there was clarification regarding inpatient days. The clarification revealed the percentage of inpatient days includes **both** inpatient and respite.

There are also new Federal regulations at **L737 through **L758** that address restraints or seclusion. These regulations refer to inpatient acute, inpatient respite and hospice inpatient facility.

It will be the responsibility of each agency to review these regulations and develop policies that address these issues.

DURABLE MEDICAL EQUIPMENT (DME) (L703)

The big change here is that hospices may only contract with durable medical equipment supplies that meet the Medicare DMEPOS (Durable Medical Equipment Prosthetics, Orthotics and Supplies) supplier quality and accreditation standards.

The surveyor will look for a letter in the hospice from the DME supplier stating the DME supplier is accredited.

If your hospice owns its own DME no accreditation is needed.

The surveyor will look for documentation that the patient, family, employees and volunteers have been educated on the safe use of medical equipment (**L702**) (**ML227**).

There has been a question regarding DME and the question is...

QUESTION: What if a DME company is not accredited but is working toward that accreditation?

ANSWER: The surveyor would expect the agency to have a letter in its file of proof that the DME is working toward certification by 9/30/09.

INFECTION CONTROL:

Let's discuss infection control. Here is what the surveyor will ask for regarding your infection control program. It will need to include the following:

--documented infection control program (**L578**) (**ML135**)

--education of patient and families on infection control in the home (**L578**)

--education of employees on infection control (**L578** & **L582)**

--a method to identify infectious diseases and an action plan (**L581**)

--policies addressing standards of practice for infection control (**L579**).

Your agency will need to identify what standards of practice for infection control will be used to develop your policies. The Federal regulations do not address a specific standard of practice.

--how the program is reviewed and updated (**ML135**)

--the person responsible for implementing and monitoring the infection control program (**ML134**)

--documentation the infection control program is an integral part of the QAPI program (**L580**)

QAPI

Now we will discuss the QAPI (Quality Assurance Performance Improvement (**L559-L576**) (**ML266-ML270**)

The new Medicare regulations have several tags that address your QAPI program. (**Handout #8**-2 pages)

At L560 the regulations states the program should involve all hospice clinical and non-clinical services including contracted and services under arrangement.

It also states the program must document evidence of the QAPI program.

At L586 the regulation states that licensed professional staff (direct and contracted staff) must be involved in the QAPI program.

The program must use data collected to do the following:
--monitor the effectiveness and safety of services and quality or care AND
--identify opportunities for improvement. (**L564**)

The written QAPI program must include:
1—a focus on high volume or problem prone areas (**L566**)
2—incidence, prevalence and severity of problems (**L567**)

3—palliative outcomes, patient safety and quality of care (**L568**)

4—tracking of adverse patient events, analyze their causes and implement preventive actions (**L569**)

At **L561**and **ML269** the QAPI must be evaluated and corrective actions identified.

The corrective actions must be documented. (**L570** and **ML268**).

Continuing with the QAPI program (**L574, 575, 576**), the governing body is responsible for assuring that the program is working to address any problem areas in patient care and hospice operations AND to improve performance in these areas.

The governing body must appoint an individual or individuals who will operate the program. This must be documented in the governing body minutes.

The QAPI program must be reviewed and revised annually by a designated group and the governing body. There must be documentation of these reviews. (**L574 and 565**) (**ML267**)

It is up to each hospice to address what problems you will focus on and how you will track those identified problems.

You will need policies for your program.

The governing body has regulations that address their responsibility to the QAPI program and the surveyors will ask for documentation to determine compliance.

NURSING FACILITY

We're going to discuss hospice in a nursing facility.

The hospice plan of care must be established in consultation with the facility. **(L773) (ML253)**

The hospice plan of care identifies the care and services that are needed and specifically identifies which provider is responsible. **(L774) (ML253)**

IT MUST BE A COORDINATED, SINGLE PLAN OF CARE.

The hospice, nursing facility, patient and family participate in developing a coordinated plan of care. **(L775) (ML253)**

The hospice updates the hospice plan of care to reflect changes in collaboration with the patient, the family and the nursing facility. **(L776) (ML253)**

The Federal regulation at **L780** states the hospice must ensure the IDG communicate with the facility medical director, the attending physician and other physicians, as needed, to coordinate.

The Medicare regulation at **L781** requires the hospice provide the facility with the following:

1. Current hospice plan of care
2. Hospice election form
3. Advance Directive

3. Advance Directive
4. Physician certification and recertification
5. Contact information for hospice personnel/24 hour on-call system.
6. Current medication list
7. Any hospice physician and attending physician orders specific to each patient.

The information I just listed must be in a clinical record in the nursing facility. It could be in the nursing facility's clinical record or in a hospice clinical record that is kept in the facility. However, the nursing facility AND hospice must know where that record is located.

The surveyor may ask both the nursing home staff and the hospice staff to identify the hospice clinical record.

TRAINING AND ORIENTATION

The hospice must provide orientation and training to the nursing facility staff. This must include: (**L782**) (**ML256**)

1. Hospice philosophy
2. Palliative care that includes comfort, pain control and symptom management.
3. Principles of death and dying
4. Care plan coordination
5. Patient rights
6. Appropriate forms and record keeping
7. When and how to contact hospice staff

The Missouri regulation at ML257 requires documentation of this education and/or that it was offered or declined.

WRITTEN AGREEMENT WITH NURSING FACILITY

If the hospice provides care to a nursing facility resident there is a written agreement signed by both the hospice and facility. **(L763)**

The written agreement includes:

1. Manner in which facility and hospice are to communicate and document to ensure the patient needs are met 24/7

2. Immediate notification of **(L765)**
   a. Changes
   b. Complications
   c. Transfer

3. Hospice determines the course of hospice care **(L766) (ML254)**

4. Facility provides room and board and continues to provide services at the same level of care prior to hospice **(L767)**

5. Hospice to provide services at the same level as if in own home including bereavement **(L768) (L770) (L772)**

6. Delineation of hospice/facility responsibility (L769)

7. Hospice must report alleged violations, by anyone unrelated to hospice, to the facility administrator within 24 hours of becoming aware of the alleged violation (**L771**)

There are regulations regarding written agreements in reference to professional management responsibilities (L655).

Handouts 10 and 10A make reference to the Federal and Missouri regulations and these tools are used by the surveyors during survey.

Your written agreements/contracts should include, at a minimum, these standards but may include more.

CONTENT OF CLINICAL RECORD (**Handout 9**)
(**L670-L678** and **ML243-ML250**)

The following items must be included in the clinical record to meet Medicare and MO state regulations:

--initial plan of care and updated plan of care
--initial assessment and comprehensive assessments and updated comprehensive assessments
--clinical notes by all disciplines
--signed copy of the election statement
--signed copy of the consent form (MO regulation)
--signed confirmation of the notice of patient rights
--responses to medications, symptom management, treatments and services
--outcome measured data elements
--signed physician certification
--signed recertification, if applicable
--advance directives
--physician orders
--identification data
--pertinent medical history
--determination of financial responsibility
--documentation of communication with coordinating providers.